An Integrative Model For The Office Management Of Delayed Ejaculation

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# An Integrative Model For The Office Management Of Delayed Ejaculation

## PERELMAN DISCLOSURES

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An Integrative Model For The Office Management Of Delayed Ejaculation

My presentation title in your program is:

“Psychotherapy For Decreased Orgasm With Normal Hormonal Profile”

But, “Decreased orgasm” is not conventional nomenclature.

Did the program committee mean:

-- Inhibited orgasm (a diminished orgasmic sensation, often called: “anesthetic ejaculation” or “orgasmic anhedonia,” a central event…

-- OR, Delayed Ejaculation: Characterized by Marcel W. & Chris Mc.M. as 2 SD from the mean IELT, or > 25 minutes… plus distress.

-- I will focus on DE.

-- IN THEIR BOOKS: M & J discussed 17 patients treated for EI; HSK treated 54 RE.

-- Over the last 40 yrs. I have treated >280, mostly urologist referred DE patients!

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An Integrative Model For The Office Management Of Delayed Ejaculation

AGENDA

• Discuss how the Sexual Tipping Point® model can illustrate an integrated treatment of sexual disorders in general, and DE in particular.

• Discuss key questions for a DE sex history.

• Provide recommendations for office management of DE from a transdisciplinary perspective.
I agree with Dr. McMahon, that
“We need to identify new drug targets.”

But we do not have a
csafe and effective drug for DE,
nor are there any current RCTs!
DE ETIOLOGY: BIOLOGICAL VARIABILITY & EJACULATORY DISTRIBUTION CURVES

FROM PE RESEARCH:
- IELT threshold data implies biological variability.
- The patterns resemble skewed distribution curves common to many human characteristics.

DUAL-CONTROL MODELS EASILY EXPLAIN SUCH PATTERNS

STP Model Depicting IELT Still WNL Vs. “Delayed Ejaculation”

DE: The net effect of all biopsychosocial-behavioral and cultural factors; depicted when “distress” is experienced and STP moves past one SD, to 2 SD beyond mean IELT (>25 min).

“HOT” Excite (+)
Faster & Greater Sexual Response

“NOT” Inhibit (-)
Slower & Less Sexual Response

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LET’S VISUALIZE THIS….

KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS

4 Containers on the scale, hold all known and unknown Mental & Physical factors regulating sexual response.
4 Containers, hold all known and unknown Mental & Physical factors regulating sexual response.

Each individual factor is ON/OFF, represented as: **HOT** or **NOT**

Sex Positive (+) or Sex Negative (-)
4 Containers, hold all known and unknown Mental & Physical factors regulating sexual response.

Each individual factor is ON/OFF, represented as: **HOT** or **NOT**

Sex Positive (+) or Sex Negative (-)

Or currently **unknown (?)**
4 Containers, hold all known and unknown Mental & Physical factors regulating sexual response.

Each individual factor is ON/OFF, represented as: **HOT** or **NOT**

Sex Positive (+) or Sex Negative (-)

Or currently **unknown (?)**

An individual’s SEXUAL TIPPING POINT is displayed on a scale labeled with a Gaussian distribution curve; a dynamic representation of their sexual response at any moment in time.
SEXUAL BALANCE: THE SEXUAL TIPPING POINT® MODEL CAN DEPICT FUTURE UNDERSTANDINGS OF SEXUAL FUNCTION AND DYSFUNCTION

(+) MICRO/MACRO FACTORS (?) BIOPHYSICAL PSYCHOSOCIAL BEHAVIORAL CULTURAL

CURRENT

MW OR CM. DISCOVERS GENETIC MARKER(S) FOR IELT!

“HOT” Excite (+) Faster & Greater Sexual Response

“NOT” Inhibit (-) Slower & Less Sexual Response

(-) MICRO/MACRO FACTORS (?) BIOPHYSICAL PSYCHOSOCIAL BEHAVIORAL CULTURAL

FUTURE

BIOLOGICAL PSYCHOSOCIAL BEHAVIORAL CULTURAL
ELEGANT SOLUTION: STP ILLUSTRATING AN INTEGRATED TREATMENT FOR A PATIENT WITH IMPROVEMENT IN DE

INTEGRATED TREATMENT, THE IDEAL SOLUTION TO BALANCE RISK/BENEFIT
• Evaluate for biological factors and provide appropriate medical treatment when needed. Today we are excluding T.

• Most common DE causes are iatrogenic, specifically the anti-sexual side effects of Rx.

Pathogenesis of Delayed/Anejaculation

<table>
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<th>Category</th>
<th>Examples</th>
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<tr>
<td>Male Ageing</td>
<td>Degeneration of afferent n. and pacinian corpuscles</td>
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<td>Psychogenic</td>
<td>Inhibited Ejaculation</td>
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<tr>
<td>Congenital</td>
<td>Mullerian duct cyst, Wolfian duct abnormality, Prune belly syndrome</td>
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<td>Anatomic Causes</td>
<td>TURP, Bladder Neck Incision</td>
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<td>Neurogenic Causes</td>
<td>Diabetic autonomic neuropathy, SCI, RP, proctocolectomy, bilateral sympathectomy, abdominal aortic aneurysmectomy, para-aortic lymphadenectomy</td>
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<tr>
<td>Infective</td>
<td>Urethritis, genitourinary TB, schistosomiasis</td>
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<tr>
<td>Endocrine</td>
<td>Hypogonadism, hypothyroidism</td>
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<tr>
<td>Medication</td>
<td>Thiazides, a-blockers, SSRIs, phenothiazines, alcohol</td>
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Office Management Of Delayed Ejaculation

Taking a focused sex history is critical!

• **Depending on your time** (the patient’s responses and comfort level, and your own), **probe for needed details** and sexual experiences that illuminate the key factors.

• **Ask specific questions, listen, clarify:**
  • “Tell me what you mean by DE.” (the CC)
  • “What do you think is causing this problem?”
  • “Tell me about your last sexual experience.”

• **This will vary with your new patients vs. established patients who are in your practice for years.**
• Obtain a masturbation status with questions regarding his: masturbation habits in general especially frequency and technique:

• Ask about: speed, pressure, teasing, “special spot”
  - how technique changes as orgasm approaches.

You can get even more specific:
- Does he use lubricant, is it a dry… an object, e.g. cloth?
- Time to ejaculation once he begins stimulating himself?
- Can he speed it up and reduce that time?
- Has anything about it changed over time?
- Location & body position, e.g. lying down, standing, sitting
- Atypical techniques, e.g. grinding forcefully against the bed
If that feels weird, or he’s looking at you weird…. TELL HIM:

“Research evidence is accumulating that men suffering from DE masturbate in a manner that is different from how their partner’s hand, mouth or vagina feels to them.”

Perhaps you even label that “IDIOSYNCRATIC MASTURBATION”

- Which was true for 70% patients (N=250) urologist referred patients below
Pay particular attention to their answers to these key questions:

- What exactly is different between your own touch, & your partner’s...
  Have you communicated your preferences to your partner… and if so, what was their response?

Look for indications of:

- Insufficient partner stimulation…OR…
- An over-rehearsed masturbation pattern; “She doesn’t do it right!”
  Which hand do you use… OK, can you O using the other one?
- Anti-erotic thoughts, e.g. “It's taking too long!”

- Is the disparity between his masturbation fantasy or porn preferences, and the reality of his partnered sex too great?
- Does he actually want to have sex with his partner?
- Is he attracted to his partner at this time?
Whether you are a urologist with 5 minutes or a sex therapist with 45 minutes

**YOU CAN TELL HIM:**

1. “Regrettably, your masturbation conditioned you to respond to very specific stimuli.”
2. “No wonder you have this problem, anyone might!”
3. “Do you know the most important step to help solve your problem?”
• **TELL HIM THE ANSWER:**
  “YOU NEED TO TEMPORARILY STOP MASTURBATING, AND DO NOT HAVE AN ORGASM UNLESS IT IS WITH YOUR PARTNER’S …”
  “… OR IF YOU INSIST ON CONTINUING TO MASTURBATE, ONLY DO SO, IF YOUR PARTNER IS PRESENT.”

• **THEN ASK:**
  “Can you do that… are you willing?”
  “Any ideas on how to do that?”

• **If not, it is critical that he change technique and often the frequency.**

• **THE EVENTUAL SOLUTION:**
  “You need to maneuver your body when you are with your partner, so your sensations and erotic thoughts become as stimulating to you, or more than when you masturbate.”
HERE ARE SOME COACHING RESPONSES I HAVE USED:

• “What would help you get more lost in the moment, be in the zone.” – provide a sports analogy?
• “OK to be more aggressive… position yourself and move in a way to maximize your own pleasure. Do not S/S!
• “Be more selfish and do not worry about her. She will take care of herself and/or you can learn how later!”
• “Not allowing your partner to experience you having an orgasm is more selfish, then not focusing your lovemaking on her!”

• If he won’t stop masturbating temporarily; negotiate a frequency reduction with no orgasm allowed within 72 hours of partnered sex.
• When he does masturbate he must change technique (e.g. switch hands) OR AGAIN: ONLY MASTURBATE IN HIS PARTNER’S PRESENCE!
The STP® model illustrates a personalized medicine that integrates appropriate drug use and counseling.

ONE DAY WE WILL HAVE A DRUG THAT WORKS AND IS SAFE!

Transdisciplinary Sexual Medicine:
Sharing resources and integrating our discipline’s knowledge to achieve a common clinical goal!

Collaboration in which exchanging information, altering discipline-specific approaches, sharing resources and integrating disciplines achieves a common scientific goal (Rosenfield 1992).

Researchers from a variety of disciplines work together at some point during a project, but have separate questions, separate conclusions, and disseminate in different journals.

Researchers interact with the goal of transferring knowledge from one discipline to another. Allows researchers to inform each other’s work and compare individual findings.
SEXUAL BALANCE:
The MAP Educational Fund’s Sexual Tipping Point® Model

THE MULTIFACTORIAL ETIOLOGY OF SEXUAL FUNCTION AND DYSFUNCTION

SEXUAL BALANCE: The Sexual Tipping Point® model depicts the continuously dynamic and variable nature of an individual’s sexual response on a distribution curve.

THE SEXUAL TIPPING POINT® The characteristic threshold for sexual expression that dynamically varies within and between sexual experiences; depicting intra & inter-individual variability.

(+) MICRO/MACRO FACTORS:
BIOLIGIC
PSYCHOLOGIC
SOCIOCULTURAL
INTERPERSONAL

(+) MICRO/MACRO FACTORS:
BIOLIGIC
PSYCHOLOGIC
SOCIOCULTURAL
INTERPERSONAL

(-) MICRO/MACRO FACTORS:
BIOLIGIC
PSYCHOLOGIC
SOCIOCULTURAL
INTERPERSONAL

KEY TO THE SEXUAL TIPPING POINT® MODEL

Represents: Mental & Physical “Causes”

Represents: Factors

Represents: Positive (+) or Negative (-) Factors.

Represents: Currently Unknown (?) Factors, hopefully to be discovered in the future.

Adding the factors results in a dynamic representation of an individual’s sexual response at any moment in time; the SEXUAL TIPPING POINT is displayed on a normal distribution curve, incorporated into a balance scale.

Neutral
Hot
Not

In 2012 the MAP Educational Fund [a 501c3 public charity] was established to make these images available for free to any sex researcher or clinician, to help illustrate their own work.

THESE IMAGES ARE ALL AVAILABLE FREE UPON REQUEST FROM: MAPEDFUND@MAC.COM

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What Does a Sex Therapist Teach in the Way of Sexual Restoration for PR Survivors?

• These men often need help accepting, that their sex life has changed. Sexual efficacy, confidence and satisfaction will need to be defined in broader terms.

• I teach how to increase the quality of friction and fantasy. Both erection and orgasm are reflex responses to pleasure. Helping him identify and request the sexual stimulation he enjoys most.¹

• Vibrators: Particularly useful for patients suffering from “sock and glove” neuro-insensitivity secondary to oncological treatments.²

¹Perelman, 2008; ²Mulhall, 2015 personal communication
WHEN TO REFER

• The More Relationship Strife, the Less Likely Medication & Education Alone Will Succeed

• Identifying Psychological Factors Does Not Necessarily Mean You Must Treat Them

• Referral
  • Patient request
  • Practice to your level of comfort
SEXUAL DYSFUNCTION MANAGEMENT GUIDELINES
BASED ON SEVERITY OF PSYCHOSOCIAL OBSTACLES

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<th>Moderate PSOs</th>
<th>Severe PSOs</th>
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<tr>
<td>Physician Sex Coach</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Rarely</td>
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<tr>
<td>Multidisciplinary Team</td>
<td>Frequently</td>
<td>Frequently</td>
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PSOs = Psychosocial obstacles

Adapted with permission from Perelman, In Balon & Segraves, 2005
We See Similar Biological Variation In Male Rats, Skewed Distribution May Suggest A Genetic Component.

- In pooled populations of male Wistar rats from 6 experiments during a 30-min standardized mating test, 3 categories of males were identified (Olivier et al., 2005):
  - with a low number of ejaculations (0-1) considered as sexually “sluggish” or “hypo-sexual”.
  - with a range of 2 or 3 ejaculations and considered as “normal” ejaculators
  - with 4 or 5 ejaculations and considered as “rapid” ejaculators or “hyper-sexual”.

Figure 6: The mean number number of ejaculations performed over the 4 last training was distributed into 3 categories (n=125) (data not published).

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Giuliano, ISSM, 2006
Kaplan published a dual control “psychosomatic” model first in 1995, but Bancroft and colleagues’ dual control model is the most well known & researched.
Office Management Of Delayed Ejaculation

THE SEXUAL TIPPING POINT®
The characteristic threshold for sexual expression that dynamically varies within and between sexual experiences; depicting intra & inter-individual variability.

SEXUAL BALANCE:
The Sexual Tipping Point® model depicts the continuously dynamic and variable nature of an individual’s sexual response on a distribution curve.

THE SEXUAL TIPPING POINT®
Illustrates the multifactorial etiology of male and female SD, which enhances our ability to diagnose and treat SDs using an integrated treatment approach.

OFFERS THE ADVANTAGE OF A QUALITATIVE CLINICAL VS QUANTITATIVE RESEARCH MODEL

® Images all available from: MAP Education Fund, a 501(c)(3) public charity MAPEDFUND@MAC.COM
Besides a biological predisposition, men with DE may have various psychosocial-behavioral & cultural predisposing, precipitating, maintaining, and contextual factors which trigger, reinforce, or worsen the probability of DE occurring in any given sexual encounter!
BEING “TURNED ON” IS MENTAL & PHYSICAL, AND SO IS BEING “TURNED OFF.”

- The mind can “turn you on” and the mind can “turn you off.”
- The body can “turn you on” and the body can “turn you off.”
- Positive mental and physical factors increase sexual response.
- Negative mental and physical factors inhibit sexual response.

All these factors combine dynamically to determine a unique variable threshold, or Sexual Tipping Point®

This mind/body concept is older than Descartes!
Dual Control Model

Physiological and Organic Issues
Psychosocial, Cultural and Behavioral Issues

Sexual Tipping Point®

Inhibition
Excitation

Variable and Dynamic Process


Slide courtesy of Jim Pfaus

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Best Possible Practice: DE

YET, DESPITE OUR ABILITY TO MODEL THE EJACULATORY PROCESS

5-HT and DA pathways are highly intermingled

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Best Possible Practice: DE

OR IDENTIFY A SLUGGISH REFLEX...

Bulbospongiosus and ischiocavernosus EMG data in human during expulsion

Giuliano, ISSM, 2006
Best Possible Practice: DE

OR, RECOGNIZE THE ROLE OF PUDENDAL NERVE STIMULATION

THE EXPERIMENTAL MODEL: PUDENDAL MOTONEURON REFLEX DISCHARGES

- Bilateral electrical stimulation of the dorsal nerves of the penis (afferent limb; DNP) and measurement of neural discharges in the motor branch of the pudendal nerve (efferent limb; PdN).

*(Johnson and Hubscher, Neuroreport, 1998)*
OR, KNOW MANY OF THE CENTRAL FACTORS IMPACTING EJACULATION’S MECHANISM OF ACTION

- Descending serotonergic pathways from the nPGI to the lumbosacral motor nuclei tonically inhibit ejaculation
- Dis-inhibition of the nPGI by the MPOA results in ejaculation
- Several brain areas are activated after ejaculation by ascending fibres from the spinal cord
- Possible role in satiety and the post-ejaculatory refractory time

Waldinger, J Urol, 168: 2359, 2002
WHETHER THESE BIOLOGIC PREDISPOSITIONS, ARE CAUSED BY 5-HT, SENSITIVITY, OR ARE RELATED TO OTHER NEUROTRANSMITTERS…

**Neurological control of ejaculation**

We know that Serotonin (5-HT) is a major player; 5-HT receptors and transporters are prominent in several centers in the hypothalamus, brainstem and spinal cord, and modulation of this system has been a rationale for pharmacotherapy development.

What other transmitters are involved in this sexual neurophysiology?

**Central Areas for Ejaculation**

- Seminal emission, ejaculation and orgasm are integrated within the CNS by several structures
  - Medial preoptic area (MPOA)
  - Paraventricular nuclei (PVN)
  - Nucleus paragigantocellularis (nPGi) in the brainstem

- Multiple regulatory neurotransmitters
  - Serotonin (5-hydroxytryptamine or 5-HT)
  - Dopamine
  - Oxytocin
  - GABA
  - Norepinephrine


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Best Possible Practice: DE

WHETHER OXYTOCIN, AND/OR...

**Influence of OT on male sexual behaviour**

- **Seminal emission and ejaculation: Human studies**
  - OT is released from the posterior lobe of the pituitary into peripheral circulation before and during orgasm and ejaculation.
  
  *Murphy et al., J Clin Endocrinol Metab (1987)*

- At peripheral level, OT promotes sperm transport during ejaculation by contracting man genital tract regions located close to the testis.

*Filippi et al., J. Endocrinol. Invest. (2003)*

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A DOPAMINE RECEPTOR SUBTYPE, THAT MEDIATES REGULATION OF EJACULATION;

ALL ARE MOVING US CLOSER TO A USEFUL DRUG TREATMENT FOR DE!

DOPAMINE RECEPTORS

- **D1**
  - Intronless genes
  - Stimulate adenylyl cyclase
  - Moderate or low affinity for antipsychotics

- **D5**
  - 60% homology

- **D2**, **D3**, **D4**
  - Genes with introns
  - Inhibit adenylyl cyclase
  - High to moderate affinity for antipsychotics

- **D5**
  - 25% homology

- **D2, D3, D4**
  - 50-70% homology

 Giuliano, ISSM, 2006
We Know the Names of Common Antidepressants and Customary Dosages

Selective Serotonin Reuptake Inhibitors (SSRI’S):
- Fluoxetine (Prozac) 20-80 mg
- Sertraline (Zoloft) 50-200 mg
- Paroxetine (Paxil) 20-60 mg
- Fluvoxamine (Luvox) 150-300 mg
- Citalopram (Celexa) 20-60 mg
- Escitalopram (Lexapro) 10-20 mg

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI’S):
- Venlafaxine (Effexor) 75-375 mg
- Duloxetine (Cymbalta) 30-120 mg
- Desvenlafaxine (Pristiq) 50-100 mg
- Trazodone ER (Oleptro) 150-375 mg

Tricyclic Antidepressants (TCA’S):
- Clomipramine (Anafranil) 75-225 mg
- Imipramine (Tofranil) 75-150 mg, Maintenance, 50-150 mg/day

Other Antidepressants:
- Bupropion (Wellbutrin) 225-450 mg
- Nefazodone (Serzone) 300-600 mg
- Mirtazapine (Remeron) 15-45 mg

• After Adam Ashton, MD with permission,
• Perelman MA. *UCNA*, May, 2011
Best Possible Practice: DE

We know they all have sexual side effects and the next slide displays a partial list of “Antidotes;” you will recognize many.

Regrettably, the numerous drugs, herbs and medication dosing strategies described in the literature for the treatment of antidepressant-related DE, offer little evidence to support their anecdotal claims (beyond some Level 3 evidence for PDE-5).

-- Nurenberg, Segraves, Clayson, Ashton
-- Helstrom et al, Ropinirole; Shabsigh, Duloxetine; Eliot, McMahon, & Waldinger, Cyproheptadine; Rabinowitz, Bupropion. (ISSM List Serve)
“Antidotes” For Sexual AE’s Found In The Literature

Frequently Suggested Antidotes, based on limited evidence:

- Amantadine (Symmetrel) 100-200 mg
- Buspirone (Buspar) 20-60 mg
- Cyproheptadine (Periactin) 4-12 mg
- Gingko Biloba 120-240 mg
- Granisetron (Kytril) 2 mg
- Yohimbine (Yocon, Aphrodyne) 5.4-32.4 mg

**Stimulants:**

- Methylphenidate (Ritalin, Concerta, Focalin and others) 15-60 mg
- Mixed Amphetamine Salts (Adderall) 15-60 mg
- Dextroamphetamine (Dexedrine) 10-60 mg

**Phosphodiesterase Type 5 Inhibitors:**

- Sildenafil (Viagra) 50-100 mg
- Tadalafil (Cialis for use as needed) 10-20 mg, (Cialis for daily use) 2.5 mg and 5 mg
- Vardenafil (Levitra) 10-20 mg

* After Adam Ashton, MD with permission, Perelman MA. *UCNA*, May, 2011

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Androgen Deficiency (low T)

We do know testosterone is critical to ejaculatory capacity!

- Decreased testosterone production
  - Impaired testicular function
- Aging effects
  - Androgen levels decrease as men age
  - Frequency of androgen deficiency increases

Total testosterone and free testosterone decrease progressively with increasing male age

Secondary causes of low T
- Chronic disease (cirrhosis)
- Feedback inhibition of T by increased E$_2$ levels
  - Alcohol abuse
  - Drug-induced P450 cytochrome induction
  - Obesity
- Hormonal deficiency (prolactinoma, ↑thyroid)
- Inflammatory conditions (Crohn’s, arthritis)
- Anabolic steroids

Drugs - low testosterone
- SSRI’s (Paxil, Zoloft, Prozac)
- Antiarhythmics (amiodarone)
- Anticonvulsants (phenytoin)
- Antifungals (ketoconazole)
- Opiates
- Phenothiazine antipsychotics
- Statins (high dose)
- Thiazide diuretics
- Ulcer Rx (cimetidine)

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Testosterone treatment

- Gels (daily application to upper arms/chest)
  - Most physiologic
  - Variable absorption
  - Can rub off on infants/women
- T injections (enanthate/propionate)
  - Non-physiologic
  - More suppression of gonadotropins
- T pellets (injected in gluteal fat)
- Skin patches
  - Common rash/irritation
- Sublingual application/other
Testosterone treatment

- Gels (daily application to upper arms/chest)
  - Most physiologic
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- Skin patches
  - Common rash/irritation
- Sublingual application/other
But, let’s not just complain about drugs as as there is only low level evidence recommending sex therapy for DE. This is regardless, of how much we know about psychology, relationships, partners and culture!

So What To Do?

First:
Recognize that DE is always a function of Bio-Psycho Social Behavioral & Cultural Factors.

It is just a question of varying proportion, depending on the individual at any given moment in time.

Bottom Line:
The negatives out way the positives for DE, like many sexual disorders.
IF THE ANSWERS ARE AS PREDICTED, THEN WHAT?

Then use these successive approximation shaping techniques, depending whether you are a physician with ~ 7 minutes or a sex therapist with ~ 45 minutes.

• “You are an expert masturbator who has conditioned yourself to only respond to very specific stimuli (humor helps here), no wonder you are having a problem... anyone would!”
• You need to temporarily stop masturbating, and not have an orgasm unless it is with partner’s...
• You need to think and move your body to maximize erotic thought and feeling... just like masturbation. “Any ideas on how to do that?”

COACH AN ANSWER

• What would help you get more lost in the moment, in the zone, sports analogy?
• Need to feel the beat _not_ a metronome.
• OK to be aggressive, position yourself and move in a way to maximize your own pleasure. Do not S/S! Be more selfish and do not worry about her, she will take care of herself or you can learn how to do both later!
• Not allowing your partner to experience you having an orgasm is more selfish!
DE is involuntary and causes distress for both the man and the partner

- high levels of relationship distress, sexual dissatisfaction, anxiety regarding their sexual performance and general health issues are significantly higher in DE men than sexually functional men

- partners believe they are not attractive for the patient. They feel unneeded and rejected

- extended coitus causes pain for the partner

- anejaculation results in a failure to conceive

- Some perceive DE to be a positive attribute that allows the man to “bestow multiple coital orgasms to his partner”
Four Diverse Psychosexual Theories
All Without Empirical Support

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<th>Characteristics</th>
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<td>- Failure to achieve sufficient mental or physical stimulation</td>
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<tr>
<td>Masturbation</td>
<td>- High frequency of masturbation</td>
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<td>- Idiosyncratic masturbatory style</td>
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<td></td>
<td>- Disparity between fantasy and reality</td>
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<tr>
<td>Outgrowth of psychic conflict</td>
<td>- Loss of self from loss of semen, fear of harm from female genitals, fear that</td>
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<td>ejaculation may hurt the partner, fear of impregnating the female, fear of</td>
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<td></td>
<td>defiling the partner with semen, hostility toward partner, not willing to</td>
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<td></td>
<td>give of oneself, guilt from strict religious upbringing</td>
</tr>
<tr>
<td>Disguised and subtle desire disorder masquerading as an</td>
<td>- Automatic functioning in the absence of genuine arousal, autosexual</td>
</tr>
<tr>
<td>ejaculatory dysfunction</td>
<td>orientation, partner’s touch inhibiting, penis becomes insensate, compulsion</td>
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<td>to satisfy partner</td>
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</table>
APFELBAUM believes that delayed ejaculation is a subtle and specific form of a sexual desire disorder.

The patient’s basic sexual orientation is autosexual (masturbatory) rather than partner (heterosexual or homosexual) focused.

- how could anyone do it (masturbate) better than me, after all I have been doing it for years?

We are accustomed to thinking that any loss of desire or erotic arousal would be reflected by a loss of erection. The delayed ejaculator not lose his erection, but the erections tend to be prolonged.

- in the presence of a partner, the delayed ejaculator’s penis is relatively insensate or numb because it is out of phase with his level of erotic arousal (automatic erections)

These men feel guilty about saying “no” to intercourse but express it through their symptom, often accompanied by a compulsion to satisfy the partner.
The premise of combination therapy is to either simultaneously or sequentially address all relevant medical/biological, psychological and interpersonal aspects that contribute to the onset and continuation of the symptom.

- Drugs may facilitate ejaculation by either a central dopaminergic, or an anti-serotoninergic, or oxytocinergic mechanism of action, or a peripheral adrenergic mechanism of action.

- Psychological intervention addresses the interpersonal and intrapsychic factors that precipitate and maintain the symptom.
Treatment of delayed ejaculation (DE) should be etiology specific, and may include patient and your couple psychoeducation and/or psychosexual therapy, pharmacotherapy or integrated treatment.

Patients with psychogenic DE are a challenging to treat population.

- Level 4 evidence to support that all require patient/couple psychoeducation and/or psychosexual therapy which may be long term.
- Good sex therapists distinguish ourselves by explicitly and comfortably asking about sex in minute detail, all while maintaining rapport with the patient.

- I use a “sex status” model.